TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROCREST SURGERY CENTER

Respondent Name
TEXAS COUNCIL RISK MANAGEMENT

MFDR Tracking Number
M4-16-3040-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
June 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was processed and paid incorrectly. Please recalculate the fee schedule allowed amounts on all surgical procedures making sure to use the correct national rate and the wage index for the city where the facility is located. This clean claim was billed requesting the surgical procedure be paid at 153% of CMS with separate reimbursement for our implants."

Amount in Dispute: $2,241.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2016	Ambulatory Surgery Services	$2,241.80	$1,093.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.
3. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged June 14, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not respond.

Accordingly, this decision is based on the information available at the time of review.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. What is the recommended payment amount for the services in dispute?
2. What is the additional recommended payment for the implantable items in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards ambulatory surgical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(f), which requires that the calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 Federal Register, or its successor.

   The following minimal modifications apply:

   (1) Reimbursement for non-device intensive procedures shall be:
   (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
   (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:
   (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
   (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

   Reimbursement is calculated as follows:

   - Procedure code 29827, service date January 26, 2016, has status indicator A2 denoting a non-device intensive procedure reimbursed in accordance with Rule §134.402(f)(1). Per Addendum AA, the payment rate for this procedure is $2,486.22. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $1,243.11 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location (CBSA 19124 – Dallas-Irving-Plano area) of 0.9847. The adjusted labor portion is $1,224.09. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $2,467.20. This amount multiplied by the Division conversion factor of 153% is $3,774.82.
   - Procedure code 29826, service date January 26, 2016, has status indicator N1 denoting packaged services included in the payment for other services rendered on the same date. Separate payment is not recommended.
   - Procedure code C1713, service date January 26, 2016, represents implantable items for which separate reimbursement was requested. Payment for the implantable items is detailed below.

2. Additionally, the provider requested separate reimbursement of implantables. Per §134.402(f), "if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission" Review of the submitted documentation finds the following implantables:

   - "Arthrex Suture Anchor BioComposite SwivelLock, Double Loaded, 4.75x22 mm" with a cost per unit of $479.00 at 3 units, for a total cost of $1,437.00;
   - "Genesys Cross FT Suture Anchor with three #2 (5 metric) Hi-Fi Sutures, 5.5 mm" with a cost per unit of $377.00;
   - "Arthrex Suture Anchor BioComposite SwivelLock C, 4.75x19.1 mm" with a cost per unit of $540.00 at 2 units, for a total cost of $1,080.00.

   The total net invoice amount (exclusive of rebates and discounts) is $2,894.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $289.40. The total recommended reimbursement amount for the implantable items is $3,183.40.

3. The total allowable reimbursement for the services in dispute is $7,588.22. The insurance carrier has paid $6,494.54. The amount due to the requestor is $1,093.68.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,093.68.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,093.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	July 26, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.